Race equality is a challenge the NHS must rise to

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8/18/2014

How staff are treated impacts on patient care, but the NHS has yet to tackle discrimination against black and minority ethnic staff like it does other patient care issues, writes ***Roger Kline****. In this article, he discusses new proposals whereby NHS organisations will be encouraged to take race equality seriously for the sake of patients.*

The NHS has so far failed to meet the challenge of race equality. Too many health services for black and minority ethnic (BME) populations are poorly commissioned and inadequately resourced. Achieving race equality in the employment and treatment of NHS black and minority ethnic staff has proved even more challenging despite the now well evidenced link between the discrimination affecting black and minority ethnic staff in the NHS and the care of all NHS patients.

Recent research has confirmed the exclusion of BME staff from senior positions in much of the NHS, an exclusion matched, and largely caused, by the treatment these staff receive throughout their working lives. BME staff are much less likely to be appointed even after being shortlisted, take much longer to be promoted, are more likely to be bullied, less likely to get discretionary pay, and less likely to access training for career development. BME staff were twice as likely as white staff to be disciplined. 25 per cent of BME NHS staff say they personally experienced discrimination last year and almost a quarter say they do not believe their Trust provides equal opportunities for career progression.

Thankfully, change may be in the air. The new NHS chief executive, Simon Stevens threw his support behind a proposed step change in the treatment and representation of BME NHS staff. NHS England has recently published a proposal for a "NHS Workforce Race Equality Standard" which it is suggested could be underpinned by a clause in the standard NHS national contract requiring NHS organisations to close the large gap in the treatment of white and BME staff in indicators such as recruitment, promotion, discipline, access to training and development, and workplace bullying.

NHS Boards are also starting to pay more attention to the sharp difference in treatment of white and BME NHS staff. This will need to include the BME absence from Boards and senior management, which is the case even in areas where very large number of patients are from BME backgrounds. The NHS is having to accept that its race equality strategy of the past decade did not work even though the 2004 NHS Race Equality Action Plan was well intentioned and had support at the highest level. Unfortunately it suffered from having no measurable outcomes and being entirely reliant on voluntary local progress.

How staff are treated impacts on patient care, but the NHS has yet to tackle discrimination like it does other patient care issues. It hasn't looked for reliable data, openly analysed, to drive improvement. Nor has the NHS listened to patients and staff to learn what lies behind the data and then implement evidence-led strategies. There are some excellent NHS Trusts who do this on workforce race equality and it works, but too many others do not.

The proposed "NHS Workforce Race Equality Standard" is not without its critics. Some have argued that it amounts to positive discrimination and will encourage quotas and lead to people being giving jobs simply because they are from minority backgrounds. Progress on race equality is hindered not helped, it is claimed, when organisations voluntarily challenge discrimination rather than being required to. But positive discrimination is illegal in the UK and the proposal's proponents point out that commissioning and regulation are proposed as a back stop to ensure that "the rest copy the best". The renewed focus the proposed Standard will bring to equality is intended to encourage more NHS Trusts to change because they want to, not because they have to. Indeed the scheme draws on evidence that suggests it adopts precisely the approach that has the best chance of making a difference.

In order to increase the number of women in senior leadership roles in research in the UK, the Chief Medical Officer Sally Davies got agreement from Ministers that applicants for National Institute for Health Research (NIHR) funding had to show evidence of institutional commitment to increasing gender equality. This was going to be referenced through achieving an Athena Swann Charter mark on gender equality. Organisations were given a two year window in order to achieve Athena Bronze status after which applications for NIHR funding would not be considered from organisations who did not fulfil the requirements of this charter. The intention is that by 2016 organisations will not be able to apply for NIHR funding unless they have achieved Athena Swann Silver status. The impact has been dramatic. All medical schools and science departments in the UK have now achieved Athena Swann Bronze status and many have achieved silver status. Data on promotions and recruitment are already showing a step change in the representation of women in leadership positions in universities

In the US, three broad approaches to promoting diversity have been tried in recent decades. Some seek to establish organisational responsibility for diversity, others to moderate managerial bias through training and feedback, and still others to reduce the social isolation of women and minority workers. The first systematic analysis of their effectiveness drew on Federal data on the workforces of 708 private sector establishments from 1971 to 2002, alongside survey data on their employment practices. They found that:

> *"Efforts to moderate managerial bias through diversity training and diversity evaluations are least effective at increasing the share of white women, black women, and black men in management. Efforts to attack social isolation through mentoring and networking show modest effects. Efforts to establish responsibility for diversity lead to the broadest increases in managerial diversity. Moreover, organizations that establish responsibility see better effects from diversity training and evaluations, networking, and mentoring. Employers subject to federal affirmative action edicts, who typically assign responsibility for compliance to a manager, also see stronger effects from some programs."*

To sum up, BME staff have waited for decades for change. The evidence now demonstrates that their poor treatment adversely impacts on all NHS patients. Some, possibly many, NHS organisations will now be encouraged to take race equality seriously for the sake of patients. But encouragement and compulsion are not alternatives on this issue. The former would be better, but for some organisations the latter may, unfortunately, be necessary.

Note: This article gives the views of the author, and not the position of the British Politics and Policy blog, nor of the London School of Economics. Please read our comments policy before posting. Featured image credit: John Blower CC BY-NC-ND 2.0

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